

MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Application For Financial Assistance For Facility Costs

This application is for help with Nursing Facility expenses, cost of nursing care in your home or cost of care in a Residential Care or Assisted Living Facility.

Return to:

I am asking for help with: _____ Nursing Facility care
 (check one) _____ Nursing care in my home
 _____ Residential Care Facility
 _____ Assisted Living Facility

The term **“YOU”** as used in this application means the person who needs financial assistance.

Information about you

Your Name (First, Middle, Last)		Social Security #	Birthdate (Mo, Da, Yr)	Age
Mailing Address: Street, PO Box, (Include apartment number, care of, etc.)			U.S. Citizen No Yes	Sex M F
City	State	Zip Code	Telephone or Message Number	
Street address and town where you actually live. Please give directions to your home. _____				
Race: White Black Hispanic Other _____				
Marital Status: Single Married Separated Divorced Widowed				
Medicare number:			Effective date:	
Do you have a disability? No Yes		Do you receive SSI? No Yes Have you ever received SSI? No Yes		

Information about your spouse:

Spouse's Name (First, Middle, Last)	Social Security #	Birthdate	Sex M F
Medicare number:		Effective date:	
Does your spouse live with you? _____ ➔ No Yes If no, list your spouse's mailing address: _____			
Date received: _____ Date logged on: _____ 45 th day: _____			

The asset questions on pages 2 and 3 are about you and your spouse.

- Cash not in bank - Checking Account - Credit Union Shares - IRA, 401K, Keough
 - Savings Account - Certificate of Deposit Accounts

Name(s) on Account	Type of Asset See Above	Name of Bank or Institution	Account Number	Current Balance Or Value

If you need more space to list accounts, use a separate sheet and check here. _____ ☐

If you are presently in a Nursing Facility, or Residential Care Facility, do you have a **Patient Account**? **No Yes**
 If so, what is the balance of your account? \$ _____

You need to tell us about any annuity that you or your spouse have an interest in. In order to qualify for MaineCare Long Term Care, the State of Maine must be made a remainder beneficiary on an annuity if you have purchased or taken action on this annuity on or after February 8, 2006. The State of Maine may get any benefits remaining in the annuity after your death or the death of your spouse or disabled or minor child, up to the amount of MaineCare benefits paid.
 Do you or your spouse have any **Stocks, Bonds, Profit Sharing, Annuities or any type of Trust Funds**? If yes, list here: **No Yes**

Do you or your spouse have any Life Insurance? If yes, list below: **No Yes**

Owner	Who is insured	Company name and address	Face Value	Cash Value
			\$	\$
			\$	\$
			\$	\$

Do you or your spouse have a Funeral Plan or Prepaid Burial? **No Yes**

Does your name or your spouse's name appear on **anyone else's** Bank Account, Savings Account, Checking Account, Credit Union Account, Stocks, Bonds, Money Market Certificates or any type of Property other than those already listed? **No Yes**

Do you or your spouse have a Safe Deposit Box? **No Yes**
 Name of Bank: _____

Do you or your spouse have Land, Buildings, Time Shares, jointly held real estate or a life estate including where you live? **No Yes**

Do you intend to return to your residence when you no longer need care in a Nursing Facility or an Assisted Living/Residential Care Facility? **No Yes**

Please provide proof of all assets and income.

Do you or your spouse have, or jointly own, any cars, trucks, boats, campers, motorcycles, snowmobiles, ATVs, trailers, skidders, tractors, or other motorized vehicles? **No Yes**
If yes, please list below:

Year	Make	Model	Name(s) of Owner(s)	Amount Owed
				\$
				\$
				\$

Have you or your spouse disposed of any **Personal Property** or **Real Estate** or closed any **Savings, Checking, or any other Financial Accounts** since February 8, 2006? This includes all things you may have given away or sold during that time period. (Examples of things you may have owned: money, bank accounts, checking accounts, stocks, land, buildings, camps, automobiles, boats, campers, etc.) **No Yes**
If yes, please list here:

Have you or your spouse recently received, or do either of you expect to receive in the near future, any payments such as Retroactive Government Benefits, Compensation, Pay Raises, Law Suit Settlements, Inheritance, etc.? **No Yes**
If yes, please list here.

These income questions are about you and your spouse.

* Alimony * Other Disability Income * Railroad Retirement * Dividends or Interest
* Social Security * Military Allotment * Other Pensions * Earnings – Wages
* SSI * Worker’s Compensation * Civil Service Annuity * Self-Employment
* Veteran’s Benefit * Other Annuities * Any Other Income
(List Claim # _____)

List Type (See Above) —————→	Your Income				Your Spouse’s Income			
Gross Amount —————→	\$	\$	\$	\$	\$	\$	\$	\$
How often received? —————→								

Do you or your spouse receive rent money from property? —————→ **No Yes**
Do you or your spouse receive money from someone who pays room and board? —————→ **No Yes**
Do you or your spouse receive money from irregular income during the year? —————→ **No Yes**

If you are in a hospital or nursing facility and your spouse is living at home, please list your **spouse's shelter expenses**. (Do not include past due payments and Security Deposits.)

Lot Rent	\$_____per_____	Rent	\$_____per_____	Cooking Fuel	\$_____per_____
Mortgage	\$_____per_____	Heat	\$_____per_____	Water	\$_____per_____
Property Taxes	\$_____per_____	Telephone	\$_____per_____	Sewer	\$_____per_____
House Insurance	\$_____per_____	Electricity	\$_____per_____	Trash Collection	\$_____per_____

Is your heating cost included in your rent? _____ ➔ **No** **Yes**

Does your mortgage payment include taxes and house insurance? _____ ➔ **No** **Yes**

Does anyone else live in the household of your spouse? _____ ➔ **No** **Yes**

Do you need help with any medical bills incurred within the last three months? **No** **Yes**
Which months?

(please send proof of income and assets for these months)

Do you have any medical insurance? _____ ➔ **No** **Yes**

Name of insurance company: _____ Premium \$ _____ How often paid? _____
Please provide the latest receipt for the premium paid.

If you are now or in the past 90 days been in a hospital, Nursing Facility, or Residential Care Facility, please tell us about this.

Facility Name _____
Address _____
Date admitted _____
Date discharged _____

Facility Name _____
Address _____
Date admitted _____
Date discharged _____

Do you have a power of attorney, conservator, or court ordered guardian? **No** **Yes**

Name: _____ Telephone #: _____

Address: _____

Please provide a copy of the court order or the power of attorney.

Is there someone who knows your financial situation whom you would like us to contact to help with this application? **No** **Yes**

Person's Name: _____ Relationship: _____

Address: _____ Telephone #: _____

If someone helped you fill out this form, please write his or her name and telephone number below:

Name: _____ Telephone #: _____

If MaineCare paid a bill for you, MaineCare has the right to collect for that bill from other medical support or medical insurance you may have.

If you get MaineCare benefits and are age **55 or older**, the State may make a claim on the assets of your estate to recover the money that MaineCare has paid for your care. **No claim will be made if the only service you get is Medicare Buy-In.** For more information about the Estate Recovery Program, please call 1-800-572-3839.

I understand the questions on this form. I certify, under penalty of perjury, that all my answers are correct and complete as far as I know, including those concerning citizenship and alien status. I agree to give papers or other information to prove what I have said. I also agree that the Department of Health and Human Services and federal officials may check with other people to prove the information I give.

Signature

Date